The Washington State Health Insurance Market: A Reality Check

A Report By The Washington State Office Of The Insurance Commissioner

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January 1998

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Executive Summary

Healthy Trends Continue

In January of 1997, the Office of the Insurance Commissioner released a study of the individual health insurance marketplace titled: "The Individual Health Insurance Market in Washington State 1993-1996." The paper examined the impact of Washington's landmark health care reforms on the insurance market, especially the impact on the "individual market."

The major findings of the January 1997 white paper included:

- More people who had been shut out of the system had access to health-insurance coverage.
- On the average, increases in premiums were moderating. Premiums in the individual market remained lower than premiums for other classes of subscribers.
- Moreover, open access to health coverage had not weakened the financial viability of health-insurance carriers. Washington state insurance carriers' solvency and revenues compared favorably with insurers in other states.
- Opponents of health-care reform repeatedly expressed the fear that carriers would leave the state. Despite these threats, no such exodus ever materialized.
- No quantifiable evidence was found to support the claims of the carriers and reform opponents that individuals were "gaming the system" by dropping in and out of coverage based solely on medical need.

A continuing analysis of Washington state's health insurance market by the Office of the Insurance Commissioner shows that it has remained healthy and viable. Review of the health insurance carriers' financial performance shows clearly that the state health insurance market is not in crisis.

Despite predictions by opponents of reform, no major carriers have abandoned the state and the balance sheets of both large and small insurers bode well for the future. Where market weaknesses are indicated by the data, they appear to be connected to high non-claims costs and their disproportionate assignment by carriers to the individual and small group markets.

Major Findings of This Review

A Viable Marketplace:

- Health-plan enrollments in Washington state continued to increase.
- On average, Washington state premiums do not vary widely between the key segments of the market – individuals, small and large groups.
- In the aggregate, premiums have stayed stable. This suggests that had community-rating requirements not been repealed in 1995, many individuals and small groups may have experienced lower premium hikes in 1996.
- Washington state premiums are consistent with increasing medical costs.

Healthy Companies:

- Washington carriers have healthier surpluses than comparable insurance carriers in other states.
- Total premiums across the three major markets—individual, small groups, and large groups—continue to bring in more money than carriers pay out in claims.
- The highest medical claims are found in the group markets, not among subscribers in the individual market.

Non-Claims Costs Need Examination:

- Claims costs have been increasing at a rate consistent with medical inflation, a sign that Washington insurance carriers have been managing claims costs.
- Non-claims costs of Washington carriers are outstripping inflation. These are the costs that should be the easiest to control.
- Across the board, Washington state insurers have assigned non-claims costs disproportionately to the small group and individual markets.
- Washington carriers report nearly 50% more non-claims costs per enrollee than carriers in other states.
- Premiums negotiated with big employers are clearly the single most important factor contributing to carriers' underwriting losses in the past five years.

Where Do We Go from Here?

The health insurance carriers have been predicting a collapse of the system ever since the reforms were enacted in 1993. These reforms were the product of a long, cooperative process of comprehensively addressing the issues of access, affordability, and reliability in health care coverage.

Since repealing many of the reforms in 1995, the Washington State Legislature's response to the new complaints by the carriers has been to rely on a patchwork approach to coverage. In addition, the legislation too often has focused solely on the individual market.

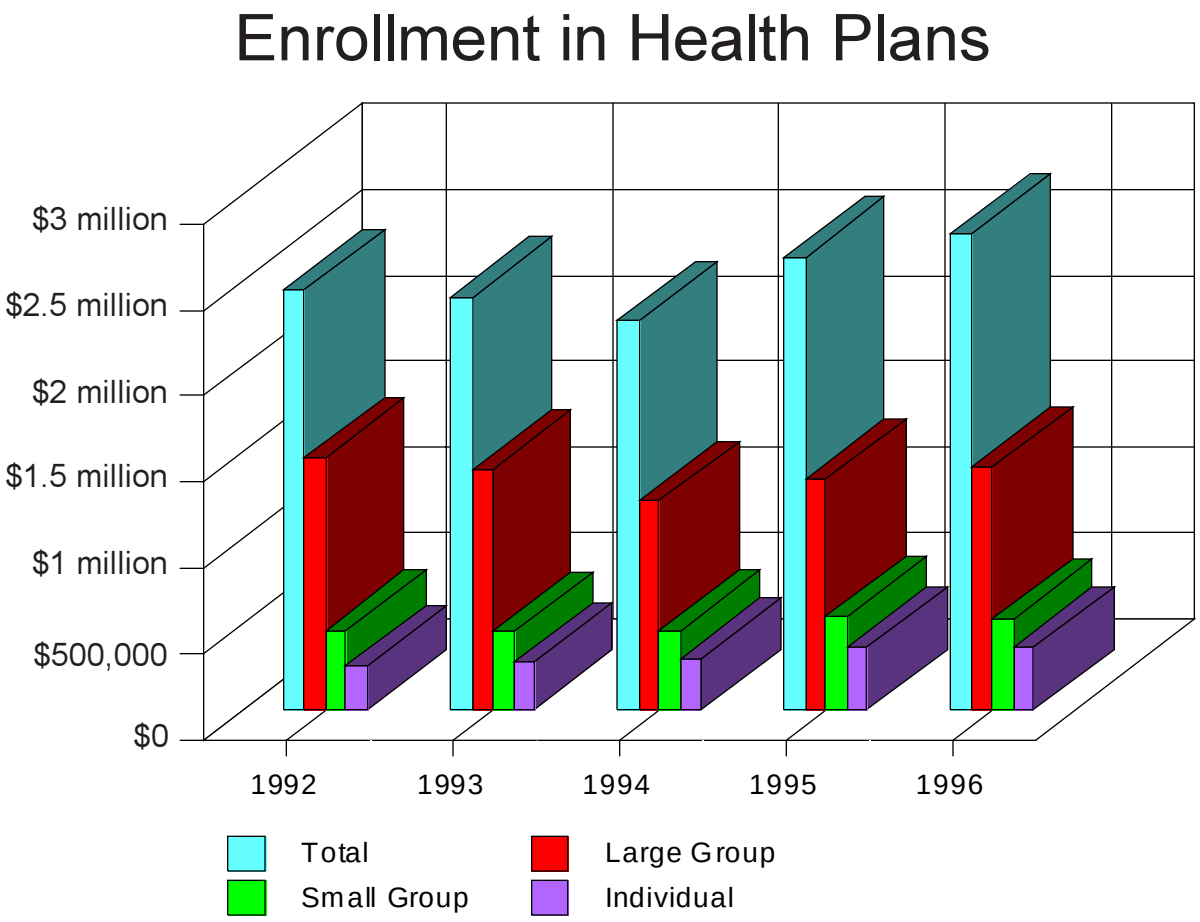
Whether attempting to address issues of the private market or of the government programs intended to expand access to coverage, the trend has been to further isolate market segments and service populations. This segmentation of coverage and markets may have serious implications for the state's public assistance areas and may have contributed to whatever destabilization of the private market has occurred.

It will be especially important in the future that legislators, regulators and executive branch agencies once again cooperate to seek comprehensive solutions to identifiable and documented problems as they arise.

I. Health insurance in Washington state, 1992-1996

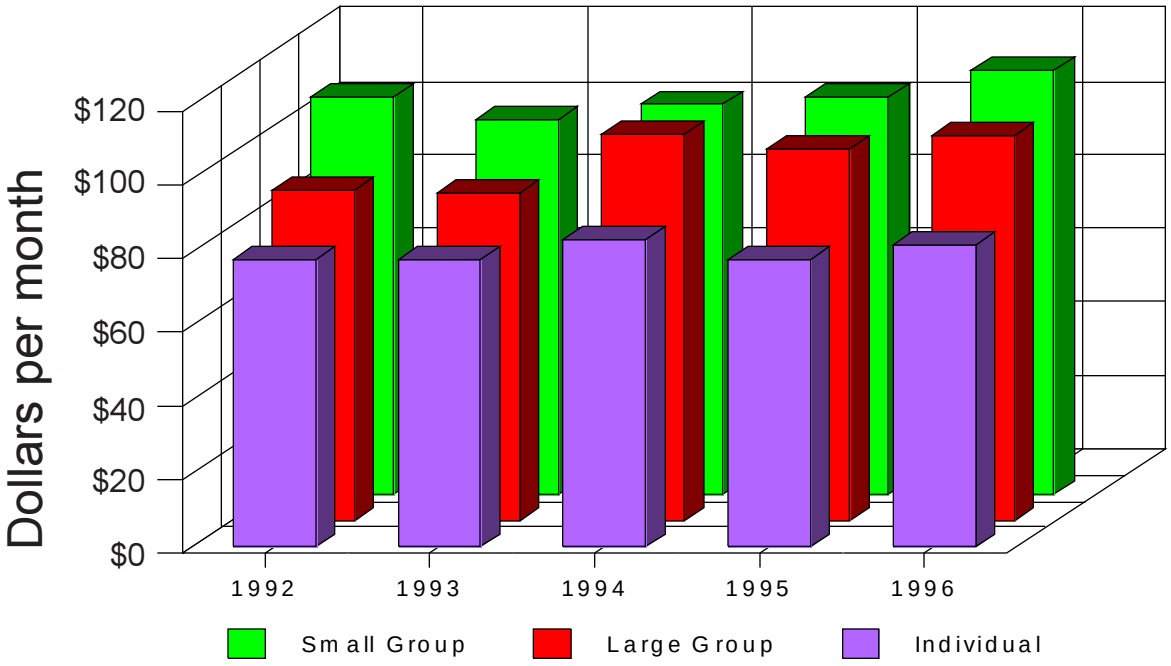
Trend line: More people receive more coverage at rates consistent with inflation.

Despite dire warnings from health insurers in 1995 and 1996, private health enrollments continued to increase in 1996, perhaps reflecting the state's growing population. However, the increase also underscores the state's continuing reputation as a good place to live and do business.



Enrollment from 1992 through 1996 increased in the aggregate as well as in terms of specific categories.

Average Monthly Premium



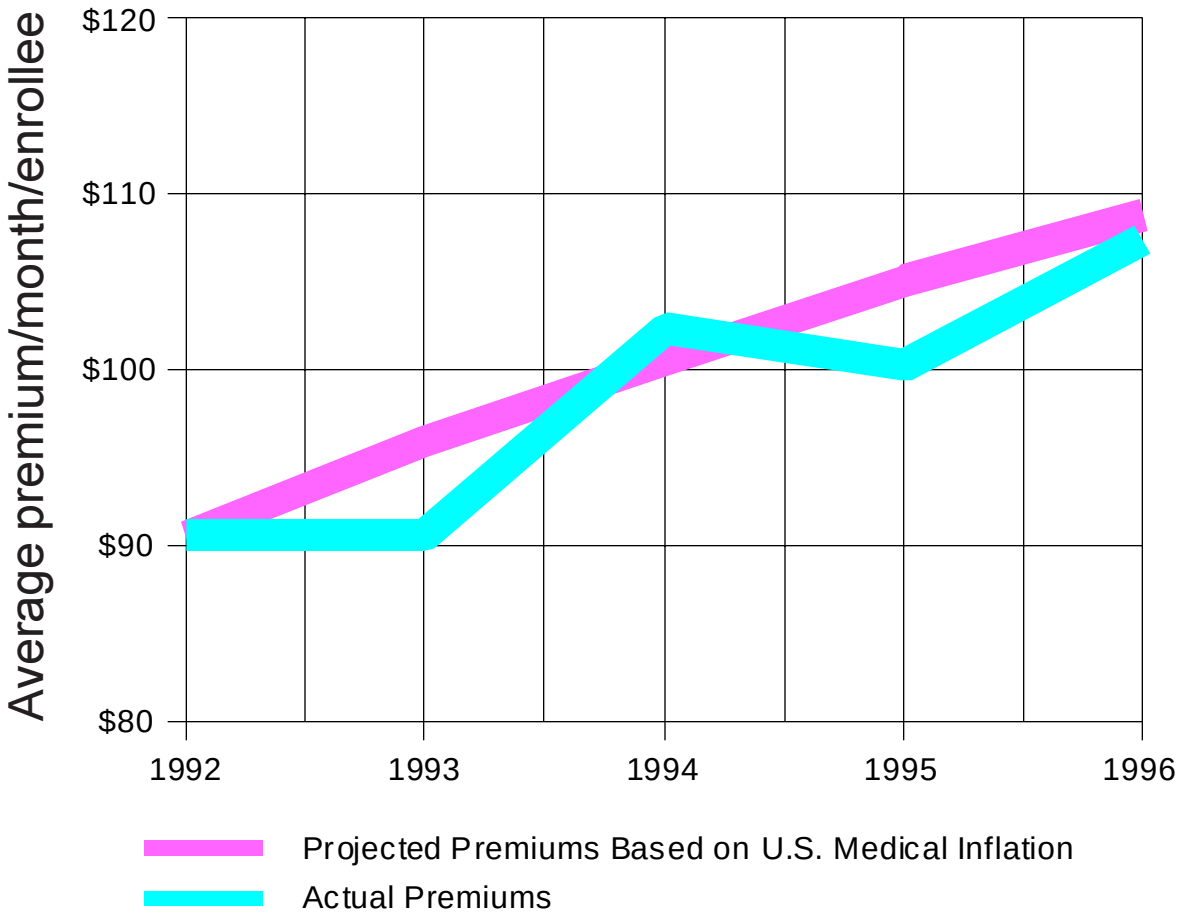
WASHINGTON HEALTH INSURANCE PREMIUMS ON THE AVERAGE HAVE NOT INCREASED SIGNIFICANTLY IN RECENT YEARS.

The market as a whole does not reflect marked premium disparities between market segments. Taken across the board (as community rating would have), Washington residents' average premiums should have been remarkably stable over the past five years.

In fact, many consumers have experienced rate increases in their personal health plans. When the Legislature repealed most of the community rating provisions of the 1993 reforms, it had a clear impact on premium rates, primarily in the individual and small group market.

Since repeal, carriers can use plan design, age, geographical areas and other factors to change the cost of health insurance for a specific consumer. Although carriers' average premium per enrollee has been remarkably stable, individual consumers have had to confront greatly varying costs and benefits available from different benefit plans.

Actual Premiums vs. Premiums Based on Medical Inflation Rates



Washington's average premium rose from 1992 to 1996 at a rate consistent with that suggested by the U.S. Medical Consumer Price Index.

As this graph shows, Washington state premiums overall are consistent with the increasing cost of medical treatments between 1992-1996. The difference in the increases in 1994 may be attributed, in part, to enrollment after the 1993 reforms by individuals who had previously been excluded from coverage. These increases moderated (as expected) in 1995 as the new enrollees were absorbed into the system.

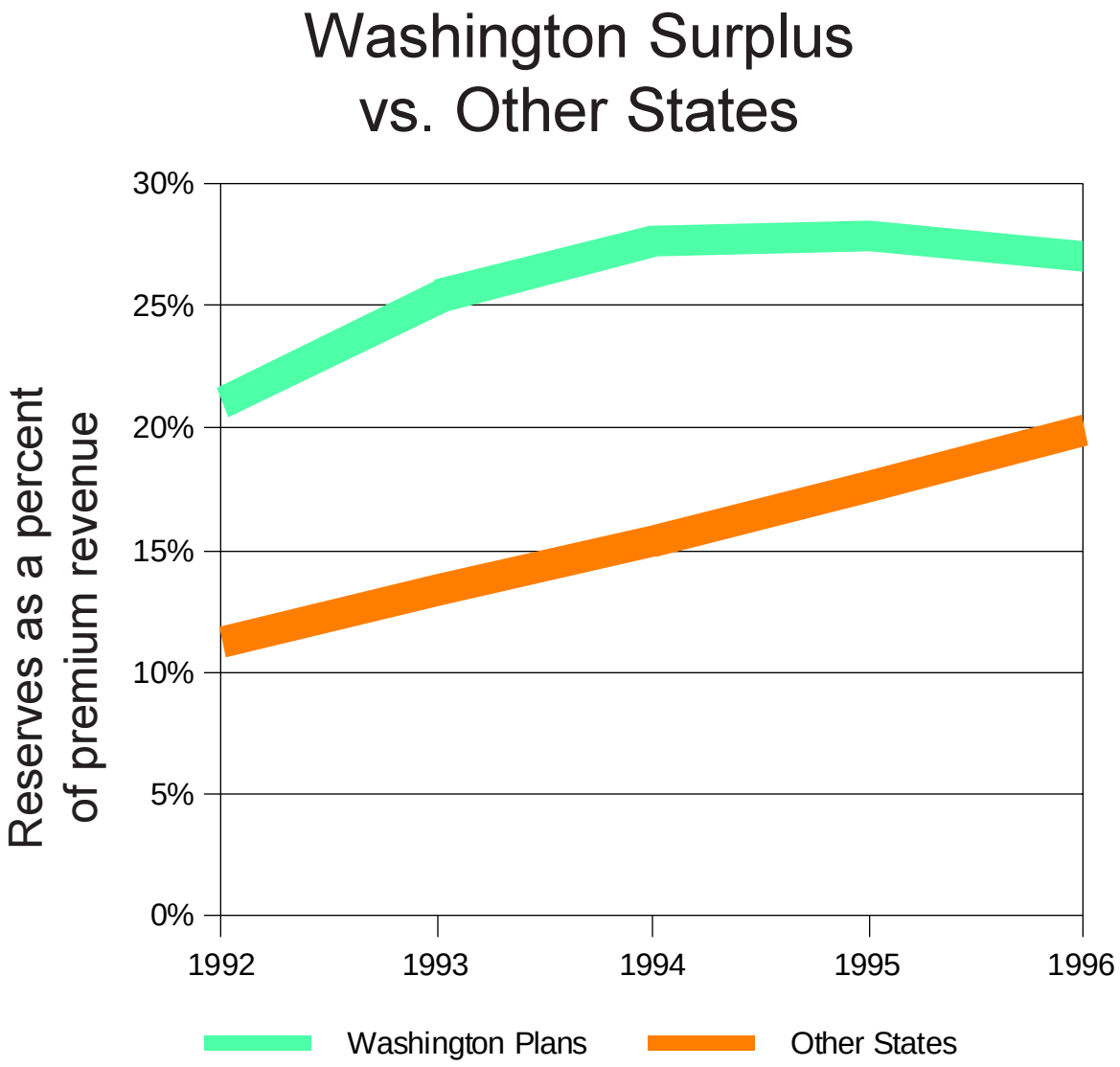
II: How healthy are the carriers?

Trend line: Surpluses are solid and premiums cover claims.

An objective look at Washington's health carriers and their finances does not reflect a market that is in crisis. In its 1997 report, the Office of the Insurance Commissioner noted that Washington carriers' financial performance compared very favorably to carriers in other states. The same is still true today. Several points illustrate this:

- The individual market to which carriers attribute most of their problems submitted lower claims than subscribers enrolled through employer groups.
- Washington carriers' surplus—which is the hedge insurance companies maintain against higher than expected claims costs—continues to run well ahead of carriers' surplus in other states.
- Total premiums from all market segments continue to bring in more funds than carriers pay out for medical care.

This last point is especially important. Even if claims exceed premiums, carriers do not necessarily experience a net loss. The premiums consumers pay to insurance carriers provide capital cash flow that carriers use in investments, generating additional revenue that contributes to their bottom line.

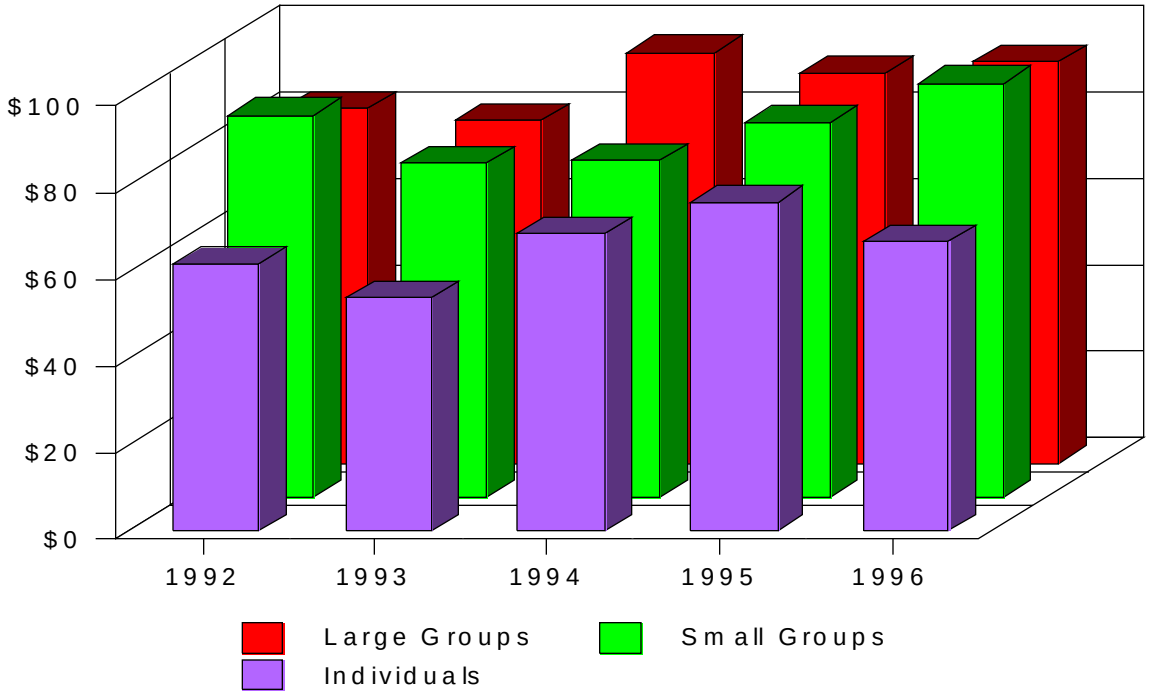


WASHINGTON CARRIER SURPLUSES CONTINUED TO GROW DURING THE PERIOD FROM 1992 TO 1996.

Although the trend of growing surpluses leveled in 1995 to 1996, the surplus level for Washington carriers was consistently high relative to the average available surplus held by carriers in other states.

The surpluses for Washington carriers moved closer to those in other states during the years following health-care reform. Even so, they remained at substantially higher levels by the end of 1996. This is a clear indication that Washington's private insurers are well prepared to handle the current level of risk in the market.

Reported Claims per Enrollee



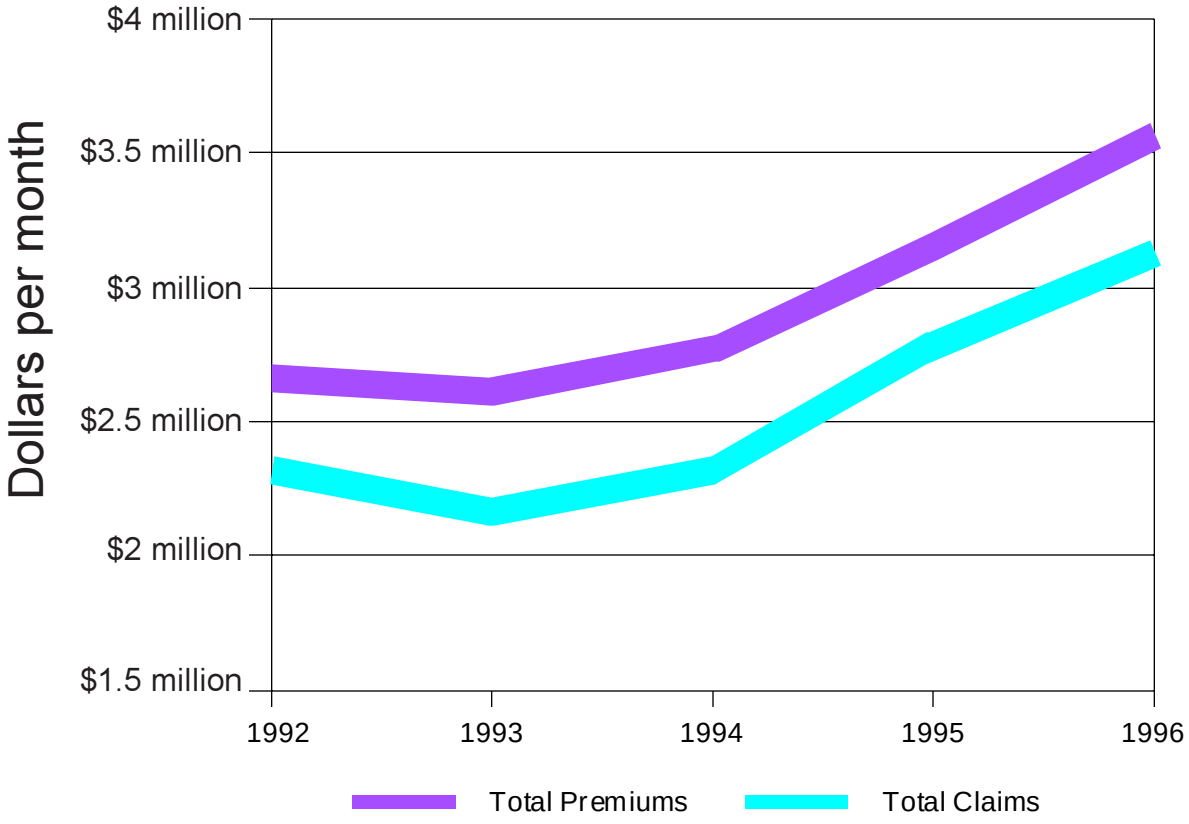
OVER THE FIVE-YEAR PERIOD, THE INDIVIDUAL MARKET CONSISTENTLY SUBMITTED THE LOWEST AVERAGE CLAIMS PER PERSON.

Over the past five years, health-insurance carriers in Washington state have criticized health care reform on grounds that it increased access for individuals, but threatened the stability of the individual market. Their argument is that the carriers must bear higher claims costs in the individual market and are vulnerable to individuals who "game the system" by waiting to sign up for insurance until they are sick. This graph shows clearly that accusation is invalid.

Throughout the five years from 1992 to 1996, the individual market consistently submitted lower claims per subscriber than either the small group or large group markets. The average claims costs for the individual market actually decreased in 1996.

Despite the industry's preoccupation with the individual market, the data clearly show that the highest claims costs per enrollee are consistently reported in the negotiated group market, dominated by large employers and big businesses.

Claims vs. Premiums



THE RELATIONSHIP OF CLAIMS TO PREMIUMS REMAINED CONSISTENT THROUGH THE STUDY PERIOD.

Although there were increases in both claims and premiums in 1994 and 1995, by 1996, the rate of change had begun to moderate.

The parallel growth of claims and premiums is consistent with a smoothly functioning marketplace. It is another indication that the marketplace has settled significantly in spite of the repeal of community rating in 1995.

With large surpluses and stable claims experience, the financial picture of Washington state's health insurers suggests they are positioned strongly for 1998.

III: Where Does the Money Go?

Trend line: The most easily controlled costs are increasing.

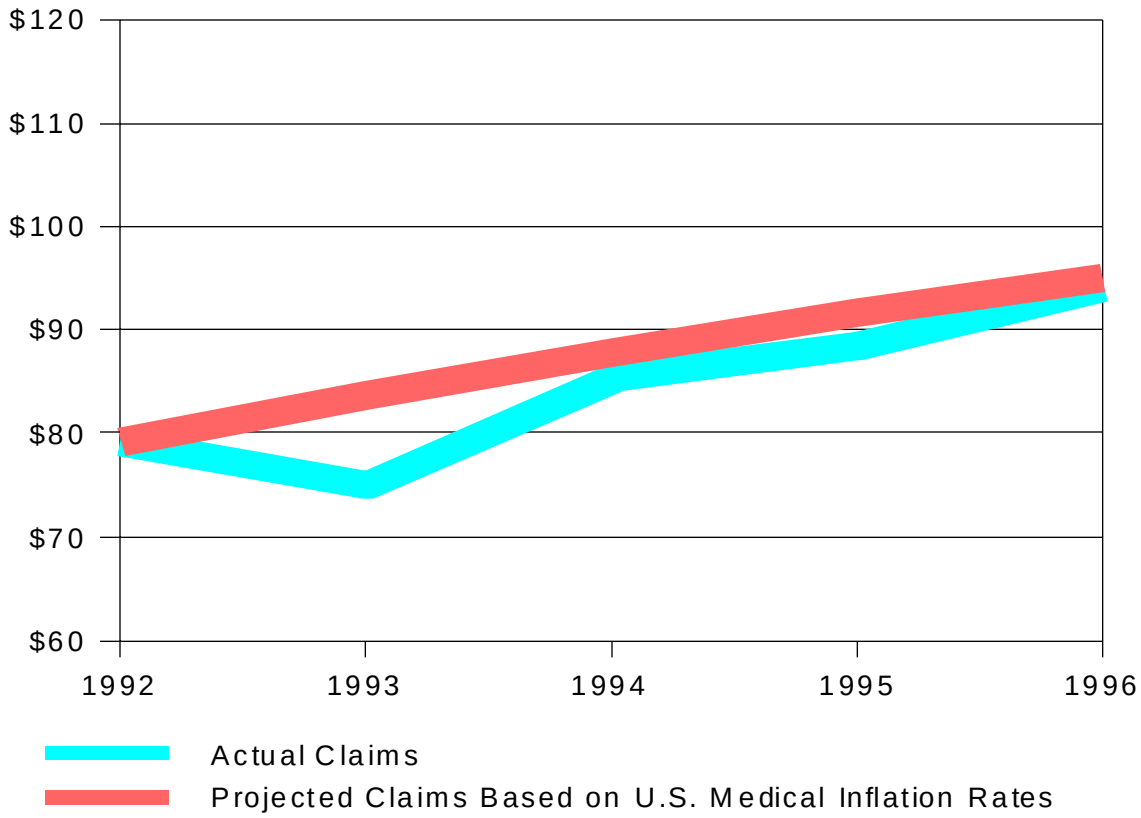
Year after year, health insurance carriers have described their inability to make ends meet. In large part, these problems are laid at the door of health-care reform. Specific blame is placed on the individual market, on open-access guarantees for Washington residents, and on individual consumers who purportedly take advantage of the rules by waiting to buy insurance until they are already sick.

In 1995, legislators, responding to the carriers' complaints, repealed much of the health care reform law passed two years earlier. They stripped away the community rating requirements that would have pooled risk across the entire marketplace. Despite these changes, carriers continued in 1996 and 1997 to urge further curbs on access, as well as other limits for consumers.

On the other hand, carriers were not the only ones who complained. With the dominance of managed care systems, consumers also complain that a gap exists between the premiums they pay and the benefits that should be available.

To explore the claims of the carriers and the concerns of the consumers, this study examined the factors that were impacting claims and premiums.

Actual Claims vs. Projected Claims Based on Medical Inflation



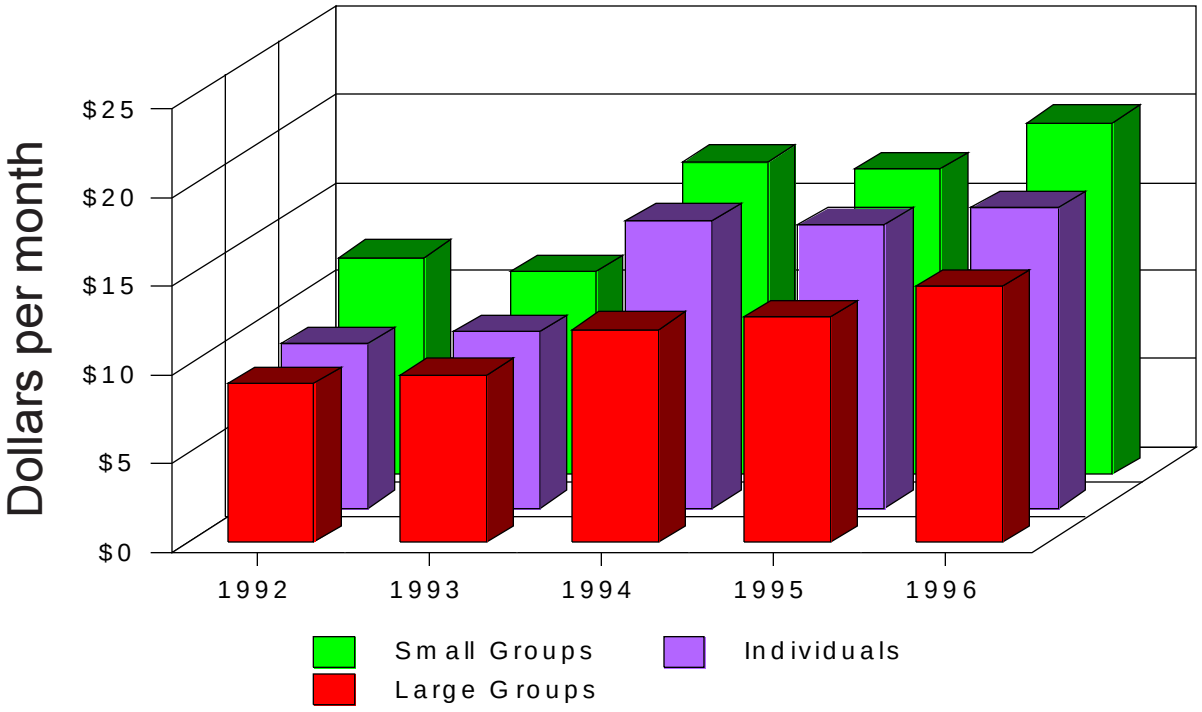
WASHINGTON CLAIMS INCREASED AT A RATE BELOW U.S. MEDICAL INFLATION FROM 1992 TO 1995.

The carriers' medical costs in Washington state increased at a rate lower than that of the U.S. Medical Consumer Price Index. The relationship of actual Washington claims to those projected on medical inflation are relatively constant for both the pre-reform and post-reform periods.

These data suggest that Washington insurance carriers have successfully managed their claims costs, even with increased access to private health insurance for those previously excluded or restricted from coverage.

To better analyze health premiums, we now need to look at non-claims costs and how carriers have assessed them.

Reported Non-claims Costs



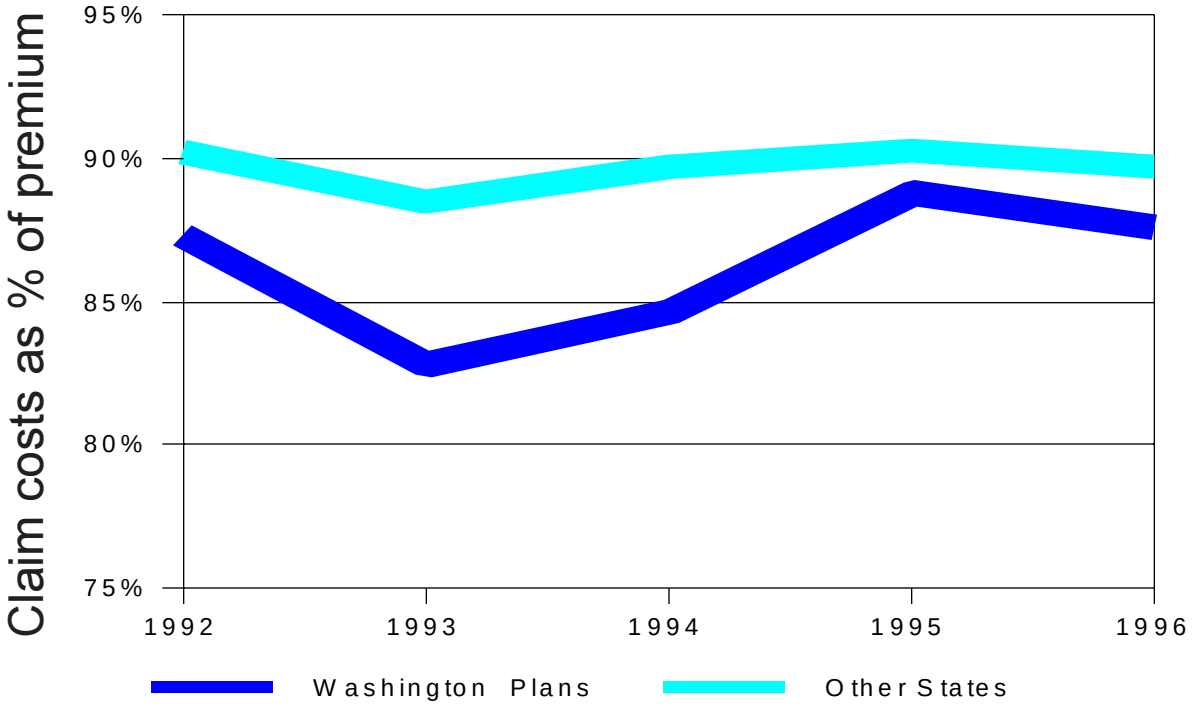
OVER THE STUDY PERIOD, INDIVIDUAL SUBSCRIBERS AND SMALL-GROUP SUBSCRIBERS WERE ASSIGNED HIGHER LEVELS OF NON-CLAIMS EXPENSES BY THE CARRIERS.

Non-claims costs are an important factor in assessing the health and stability of any insurance marketplace. These costs include the salaries paid to the insurers' top executives, as well as their workforce. They also include the costs of advertising, marketing research, sales commissions, contributions to reserves, and lobbying expenses.

Carriers have consistently assigned these costs disproportionately to the small group and individual markets. In fact, small employers pay the most when it comes to the assigned non-claims expenses.

The carriers allocate these costs to specific market segments. It is to an insurer's benefit to assign these costs in the least competitive sectors. In Washington state, this enabled carriers to hold down rates in the most competitive market segment – the negotiated, or large group, market.

Washington Claims Costs as a Percent of Premium Dollar vs. Other States



WASHINGTON CARRIERS SPEND LESS OF THEIR PREMIUM DOLLAR ON CLAIMS THAN CARRIERS IN OTHER STATES.

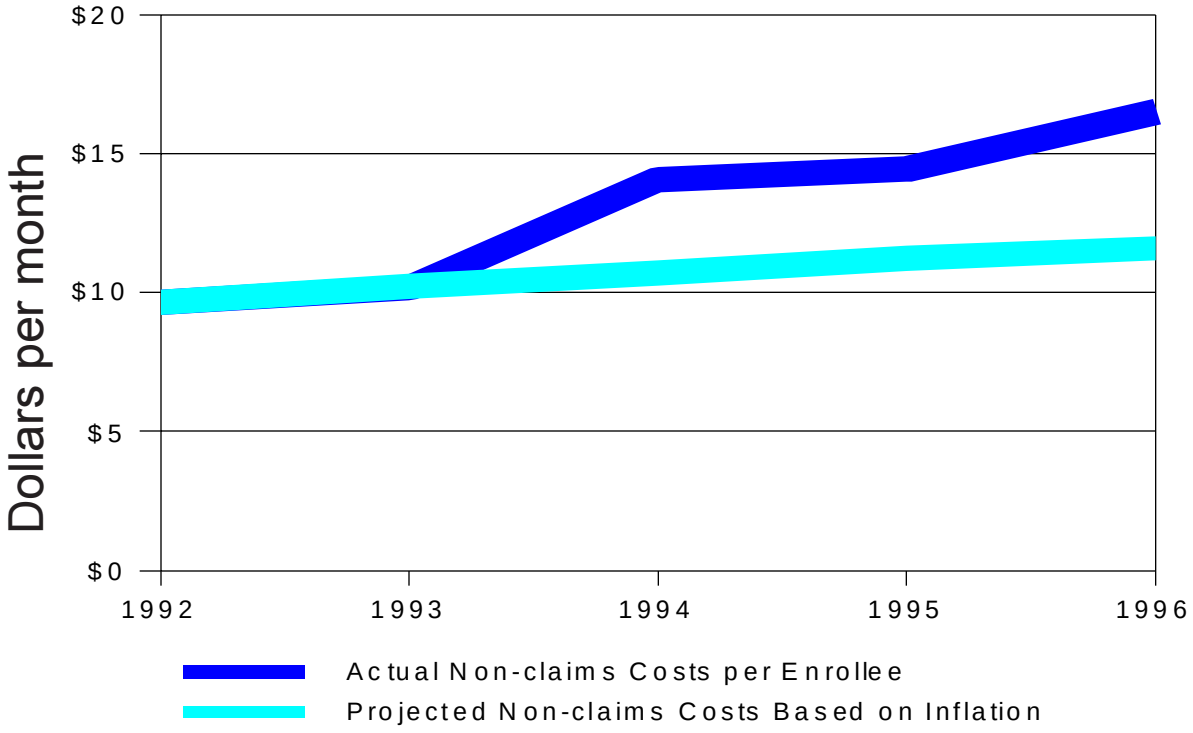
Washington plans spent proportionately less of their premium dollar on claims than carriers in other states, although more attention to rate-hike filings in recent years by the Office of the Insurance Commissioner has clearly helped narrow the gap. Claims costs are payments by the insurance carrier to cover the medical bills of their subscribers.

Carriers use this figure to compute what they call a “loss-ratio.” However, these payments are not really a “loss” in terms of overall financial performance. They are simply the costs of providing contracted services in health insurance plans.

Washington’s lower “loss-ratios” in recent years show the value of a more active rate review by the OIC, which in 1993 began requiring carriers to fully justify health insurance rates increases. Because the state’s “loss-ratio” remained lower than other states’ even after absorbing the costs of reform, the data demonstrate that Washington is doing a better job of managing medical costs.

The data overall suggest that Washington carriers should be more attentive to improving administrative efficiencies and eliminating fiscal waste, especially in non-claims costs.

Actual Non-claims Costs vs. Projected Non-claims Costs

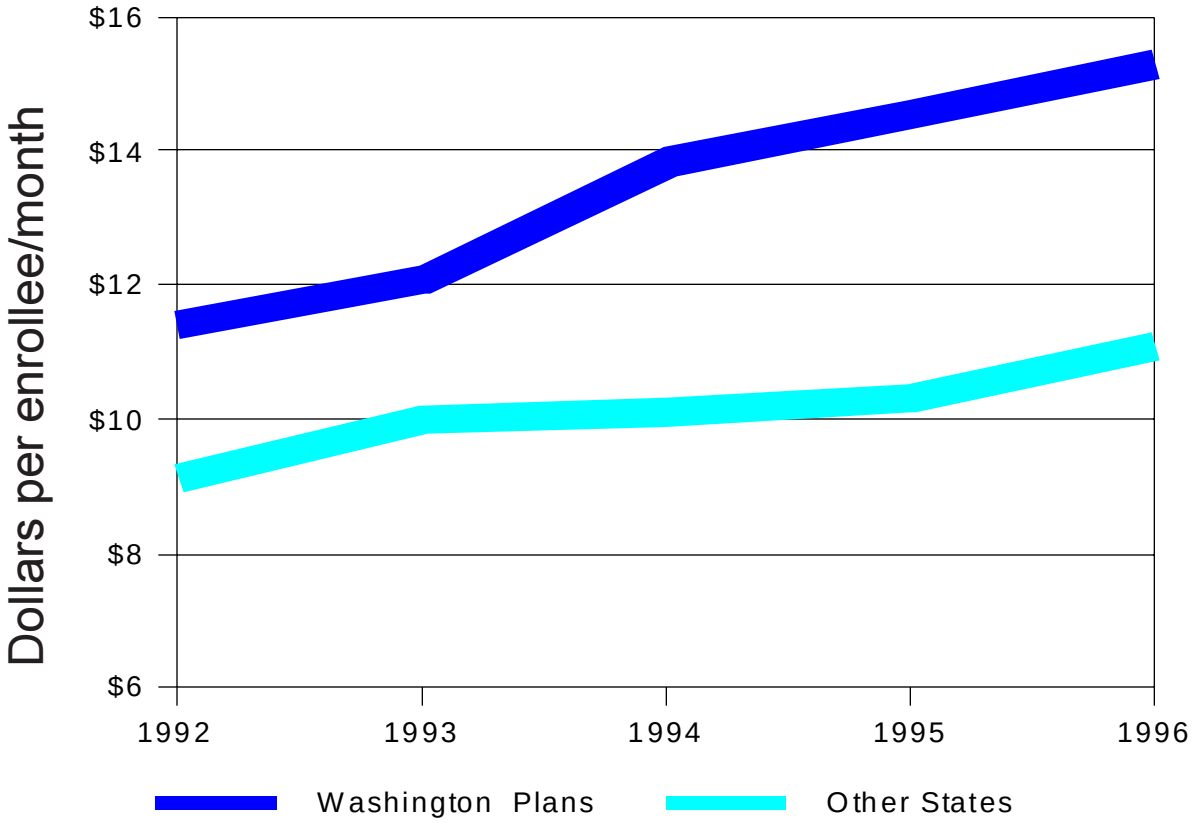


CARRIERS' OVERHEAD EXPENDITURES BEGAN TO GROW AT A MUCH FASTER RATE THAN INFLATION IN 1993.

The data presented here show that carriers' overhead spending began to grow at a much faster rate than inflation beginning in 1993. This is in direct opposition to the trend in claims costs, which have been below the rate of inflation through the study period.

Administrative costs should be the most easily controllable expenses. When businesses enter tight times, they cut back unnecessary expenses and try to make the same dollars stretch further.

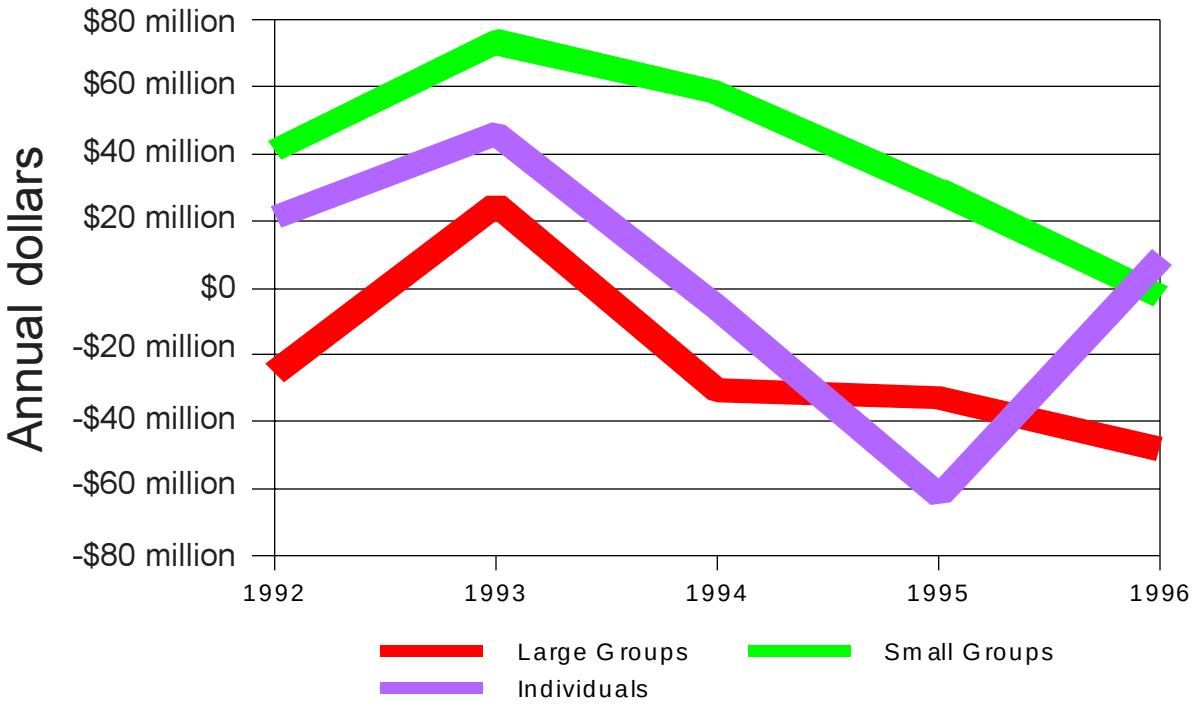
Washington Non-claims Expenditures vs. Other States



WASHINGTON CARRIERS SPEND PROPORTIONATELY MORE OF THE PREMIUM DOLLAR ON NON-CLAIMS EXPENSES THAN CARRIERS IN OTHER STATES.

Washington carriers are spending increasingly more dollars on non-claims expenses — advertising, salaries, marketing research, sales commissions, lobbying fees, etc. — than are comparable carriers across the country. Washington carriers report nearly 50% more non-claims costs per enrollee.

Underwriting Gains or Loss on Health Plans by Market Segment



CARRIERS EXPERIENCE THE GREATEST UNDERWRITING LOSSES IN THE NEGOTIATED, OR LARGE GROUP, MARKET.

Underwriting losses (or gains) do not reflect a carrier's bottom line in terms of net profit and net loss. That is because these data do not include the investment income gained from premium dollars–the major source of carrier profit. However, the data furnish a reasonable picture of what has happened in the marketplace regarding claims and premiums over the past five years.

These data confirm that the large-group market has consistently produced the largest underwriting losses for the carriers.

Until 1996, small employer premiums accounted for a significant portion of carriers' underwriting gains. The individual market, meanwhile, dipped below the break-even mark in 1994 but then recovered in 1996.

The lower-than-cost premiums bestowed on big employers by insurers are clearly the major factor contributing to the carriers' underwriting losses.

IV. Conclusions

Trend line: ***High non-claims costs, combined with underwriting losses in the negotiated, or large group, market are the major factors contributing to what financial concerns remain in the wake of Washington's health care reforms.***

As legislators and the Office of the Insurance Commissioner analyze the health of the industry in 1998, this study recommends two issues that may warrant closer examination:

- Carriers should be encouraged to put increased focus on improving administrative efficiencies, trimming waste, and controlling non-claims costs.

- Efforts should be directed at reducing the fragmentation of the health insurance market.

A re-evaluation of the idea of community rating may be recommended. In any event, the assignment of non-claims expenses by carriers across market segments should be examined. The individual and small group subscribers and purchasers should not be subsidizing the negotiated market.

An additional challenge lies in a more comprehensive analysis of public policy decisions in government-sponsored coverage. For example, there is a very real danger that changes in benefits and premiums rates in the public sector, i.e., the BHP, may have a deleterious impact on the private insurance market.

The Legislature and the various agencies that work in the health care system should improve communication and analysis to guard against unanticipated consequences.

Last, this study reveals that the focus of the health insurance debate since the 1993 reforms may have been somewhat misplaced. The emphasis on the individual market has distracted attention away from other serious concerns, especially the problems facing small employers.

Appendix A

Methodology: Explanations of Calculations

All data are taken from annual reports filed by the carriers with the National Association of Insurance Commissioners (NAIC) and the Washington State Office of the Insurance Commissioner.

Annual reports as filed by the carriers often have mistakes or anomalies. Where we could discover those and clear them up with the carriers, we have done so.

The data used for this report reflect the performance of the 24 Health Care Service Contractors (HCSCs) most active in Washington's commercial health insurance. Limited purpose carriers such as dental are not included because they do not offer the type of medical insurance covered by reforms. HMOs were not included because their data cannot be aggregated with HCSC data due to differences in the way they account for claims vs. non-claims costs. However, it should be noted that HMO performance in Washington state follows the same trends as shown in the HCSC data.

The 24 study carriers represent about 55% of the total commercial market made up of sales to individual, small employer and large employer purchasers. For this group of 24 carriers, sales to individuals makes up about 13% of the business reviewed here, sales to small groups makes up about 21%, and negotiated contracts about 49.5%. The remainder are principally government contracts, including the Basic Health Plan.

The 24 carriers together dominate the individual insurance market, however, selling to about 85% of the people who buy coverage directly. The trends indicated by the data are clearly representative of the Washington market as a whole. There are variations in the performance of specific carriers, of course, that may be better or worse than the average.

The 14 largest of the 24 carriers are registered in the state of Washington as "non-profits." All of their capital comes from policyholders. Most of the 10 "for-profit" carriers are owned by non-profit carriers, hence, most of their surplus or capital also comes from policyholders. Some carriers have a small portion of debt financing, but this is rare in this industry. Debt and related interest is paid by policyholder premiums.

With policyholder-supplied capital, these carriers do not have to attract investors and they do not have to pay dividends. Generally, members of the public believe that "non-profit" carriers operate on a break-even basis, with all costs covered

including a contribution to reserves at levels necessary to maintain financial soundness. They do not expect carriers to seek to accumulate revenues (net profit). However, some carriers believe that there should be no limit to the amount that they may accumulate equivalent to net profit.

The data for the other states cited on some graphs are derived from a sample of 36 HCSCs offering full health coverage in states other than Washington. The majority of these are “Blue Cross/Blue Shield-type” carriers. Their annual premiums total more than $30 billion. As the major carriers in other states, these companies represent a large portion of the national HCSC market.